HealthSelect

Maricopa Integrated Health System

Member Handbook and Certificate

Contract Year 2001

HealthSelect

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Welcome to HealthSelect

Congratulations on choosing HealthSelect! This HealthSelect Member Handbook and Certificate is a comprehensive resource designed to answer questions about your medical coverage and your HealthSelect 2001 services, benefits and procedures. Please retain this handbook for reference. If you have questions not answered in this handbook, please call the MIHS Health Plans Customer Service Department at 602-344-8760.

As our customer, it is important that you fully understand your benefits. This member handbook and certificate is your best resource to help you properly access your health care, and it will help you more fully understand the benefits extended to you, the member. Please review it for a complete understanding of the benefits offered through HealthSelect and keep it for future reference.

The HealthSelect benefit year begins January 1, 2001 and ends December 31, 2001. All benefits and services discussed in this booklet are applicable to this contract/benefit period only.

Introduction

This is a great year for you to make healthy choices, and HealthSelect has designed several new benefits and wellness incentives to help you get on your way. This member handbook will describe in detail the new incentives and benefits and tells you how to access services. Some of the new features for HealthSelect 2001 include:

- Discounted Lasik eye surgery
- Student health insurance allowance for out-of-area students
- Wellness incentives for health and wellness-related activities

These discounts, allowances and incentives can really add up, so be sure to carefully read the Summary of Supplemental Benefits on pages 18-20 of the handbook.

HealthSelect has also enhanced several benefits for 2001, including an increased number of visits for chiropractic and alternative medicines; lower copays for prescriptions filled at Family Health Center pharmacies home delivery of up to three months of maintenance medications; increased hearing aid allowance of $500; increased alternative medicine supply allowance of $60; and reduced benefit coverage for alternative medicine ($5) and prenatal visits ($0).

Our network of hospitals, primary care physicians and specialists continues to grow to give HealthSelect members more choices than ever. As a HealthSelect member, you will continue to receive the added benefits of dental, chiropractic and alternative medicine services. Members can still use HealthSelect's self-referral process to visit network Family Practice, Internal Medicine, Pediatric and OB/GYN specialists with no referral from their Primary Care Physician or prior authorization from the health plan.

With HealthSelect, there is no pre-existing condition limitation and no deductibles to meet. Members must receive all care by HealthSelect network providers, including physicians, hospitals, pharmacies and/or ancillary providers. Members are always covered for emergency care, anywhere in the world.

Definitions

Approved Provider — The HealthSelect physician, institution, hospital, ancillary professional or vendor that fulfills conditions of participation for delivery of care and services to health plan members.

Authorization — (Also referred to as "prior authorization"); an administrative process whereby MIHS Health Plans prospectively reviews requested services to determine medical necessity and appropriateness.

Contract — The **HealthSelect Member Handbook/Certificate** and other documents provided to the member during the period of membership.

Contract Year	The calendar year from January 1st through December 31st. The contract year begins on the effective date of member enrollment and ends on December 31st.
Copayment	The amount a member pays directly to the participating health care provider at the time covered services are provided. Copayments are usually collected prior to receiving services.
Customer Service Department	The department that stands ready to answer your calls regarding covered services/ benefits, access to such services and any type of concern about HealthSelect.
Dependent(s)	Persons in a Subscriber's immediate family, i.e. spouse and natural and adopted children, eligible for HealthSelect coverage as determined by the employer. Children are considered dependents only through the last day prior to their 19th birthday. However, if your unmarried child is a full-time student at a college, university, technical school or other institute of learning, he or she can continue coverage through the age of 25. You may be asked for proof of continued registration of a full-time student. Failure to provide proof will result in dependent's disenrollment in HealthSelect.
Emergency	The sudden onset of a medical condition such that the absence of immediate medical attention could be expected to result in: 1. Loss of life 2. Serious impairment of bodily function; or 3. Loss or serious dysfunction of any bodily organ or part or otherwise 4. Placing the member's health in serious jeopardy.
Formulary	The HealthSelect-approved list of covered prescription medications available to HealthSelect members. HealthSelect requires use of generic prescription medications when available and when not contraindicated by the patient's medical condition.
Full-Time Student	An unmarried dependent, up to but not more than 25 years of age, who attends an accredited college, university, technical school or other institution of higher learning following graduation from high school and meets full-time requirements of that institution.
HealthSelect	A managed care health plan administered by MIHS Health Plans to provide coverage for Maricopa County eligible employees and dependents.
Homeopathy	A system of medicine that strives to treat disease by stimulating the body's own defense and repair systems with highly diluted doses of medication.
Homeopathic Medicines	Homeopathic medicines are drug products made by homeopathic pharmacies in accordance with the processes described in the Homeopathic Pharmacopoeia of the United States, the official manufacturing manual recognized by the FDA.
MIHS Health Plans	A managed care organization owned by Maricopa County (Arizona) government which operates four health plans including HealthSelect.

Maricopa Integrated Health System (MIHS)	An agency within Maricopa County government that operates an integrated health care delivery system consisting of the Maricopa Medical Center, 12 Family Health Centers, a Comprehensive Healthcare Center and a managed care organization, the MIHS Health Plans.
Medically Necessary and Medical Necessity	All health care and services received by HealthSelect members must be medically necessary and conform to the following criteria of medical necessity: Arizona Administrative Code R9-22-101 (69) defines medically necessary as "those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to: Prevent disease, disability and other adverse health conditions or their progression, or To prolong life." Medical necessity is also established if: The disease or condition considered for treatment is one in which the safety and effectiveness of the proposed therapy has been demonstrated and documented, The stage of disease or condition is such that therapy can affect the outcome in a positive manner and/or The recipient of care has no other conditions which substantially reduce the potential for successful recovery.
Member	A Maricopa County employee, retiree or dependent who is enrolled in HealthSelect and is eligible for covered benefits.
Osteopathic Manipulation/ Craniosacral Therapy	The subtle movement/manipulation of body parts, including muscle, bone and connective tissue, to re-establish a healthy balance between organ systems and the nervous system.
The Plan	Refers to HealthSelect, the managed care health plan for Maricopa County employees, as previously defined in this HealthSelect Certificate.
Primary Care Physician (PCP)	A physician, such as family practice, internal medicine, or pediatrician, who is responsible for the overall management of a member's health care. During pregnancy, the member's obstetrician assumes the role of a PCP for the term of the pregnancy and postpartum care.
Provider Network	Physician, hospitals, ancillary providers and other health care vendors approved by or contracted with HealthSelect to provide care and service to its members. HealthSelect delivers services through its major provider network: Maricopa Integrated Health System (MIHS) which includes Maricopa Medical Center (MMC), 12 Family Health centers, the Comprehensive Healthcare Center (CHC) at MMC and an expanded network of other hospitals and private physicians.
Subscriber	The employee who enrolls in HealthSelect under this agreement.
Urgent	A condition requiring medical attention within a few hours; a condition which is not immediately life threatening or severe, but for which delay of service, until the member can be treated by his/her primary care physician, would be detrimental.

Member Rights and Responsibilities

Member Rights

You Have the Right To

- Receive the services and benefits outlined in the HealthSelect Member Handbook/Certificate.
- Choose a primary care physician from the provider network.
- Be treated with respect and dignity.
- Expect confidentiality of all information, including medical records, unless required by law. You may look at your medical records as allowed by federal and state laws.
- Privacy during treatment.
- Know the name and credentials of professionals providing treatment, information about diagnoses, treatment options and expected results.
- Participate in decisions about the kind of care you receive.
- Refuse any treatment and to be informed of the consequences of **not having** the treatment.
- Register complaints and have them heard and resolved.

Member Responsibilities

It Is Your Responsibility To

- Present your membership identification card when receiving care/treatment.
- Pay the applicable copayment at the time care/treatment is given.
- Arrive at your appointment on time. Please cancel 24 hours in advance if you cannot keep your appointment.
- Utilize the authorized provider network except in emergency life-threatening situations.
- Schedule appointments with your primary care physician rather than using Emergency/Urgent Care facilities for non-emergent/non-urgent illnesses.
- Give true and complete facts about your health and inform your physician of any unexpected changes in your condition and follow prescribed treatment regimen.
- Treat providers and their staff with dignity and respect.

Membership Cards

HealthSelect provides members with an identification card that includes their name, date of birth, ID number and gender.

You should carry your member ID card with you at all times. Your HealthSelect member ID card is required for all health care services, especially urgent care and emergency room services.

Permitting someone else to use your membership card to obtain services is prohibited and will result in termination of your coverage. If your card is lost or stolen, please call MIHS Health Plans Customer Service Department at 602-344-8760 or 1-800-582-8686.

Choosing Your Primary Care Physician

You must choose a primary care physician (PCP) for each family member covered under HealthSelect. Most medical services are provided and/or coordinated by your Primary Care Provider (PCP), including referrals to specialists when needed. You may choose from general practice, family medicine, pediatric, internal medicine or OB/GYN PCPs. **If you do not choose a Primary Care Provider, you will be assigned one.**

Refer to the enclosed Provider Network Directory to choose your PCP. Your PCP must approve all your medical care, except as noted on following page.

If you wish to change your PCP, please contact the MIHS Health Plans Customer Service Department at 602-344-8760. The PCP change will become effective the first day of the following month. You will be allowed to change PCPs no more than four times per contract year.

How to Access Services

Most medical services are provided and/or coordinated by your Primary Care Provider (PCP) including referrals to specialists and hospitalizations. You do not need a PCP referral to HealthSelect-contracted:

- Dentists
- Chiropractors **(PCP referral and prior authorization from HealthSelect is required for additional visits beyond benefit limit of seven.)**
- Alternative medicine providers
- Weight loss counselors
- Eye exam providers
- Lasik surgeons

Please contract your PCP or HealthSelect Plan for information on how to access specific medical services.

It is necessary to make an appointment each time you see your PCP, specialist or dentist. It is your responsibility to call and cancel if you will not be able to make your appointment.

How to Set Up a Physician's Appointment

1. Have your HealthSelect ID card with you when you call for an appointment. You will need to give the ID number on the card.
2. Tell the receptionist/clerk your
   - Name
   - ID Number from your card
   - Primary Care Physician's name
   - Reason for requesting an appointment (if urgent "same-day" treatment is required, let the receptionist/clerk know; you may be transferred to a triage nurse)
3. On the day of your appointment
   - Be on time
   - Show your ID card
   - Pay applicable copayments
4. **Be sure to call and cancel your appointment one day in advance if you cannot keep it.** This will assure someone else the opportunity to have an appointment.

Specialist Physician's Appointments

You do not need a PCP referral or prior authorization from HealthSelect in order to access the following specialists:

- Pediatricians
- Family practitioners
- Internists
- OB/GYNs

For all other contracted specialists you do not need HealthSelect prior authorization. However, **you will need a referral from your PCP.** You may not use a non-contracted specialist without prior authorization from HealthSelect.

If you need to cancel an appointment with a specialist, please notify your PCP, as well as the specialist including all referrals to specialists.

Hospitalization

Should the need arise for you to be hospitalized, your PCP will make all the necessary arrangements. All scheduled admissions must be prior authorized. In the event of an emergency, go to the nearest hospital. You should notify HealthSelect within 48 hours of receiving treatment. See "A Guide to Appropriate Use of a Hospital Emergency Room" on the next page.

Your hospital admission at a selected, contracted hospital will be determined by your PCP with prior approval from HealthSelect.

After Hours Primary Care

HealthSelect members who need to see a doctor after regular office hours, on weekends or holidays may visit (no appointment necessary) one of five NEXTCARE locations in Maricopa County. Members may access these locations only between 5 p.m. and 8 p.m., Monday through Friday, and on weekends and holidays from 8 a.m. to 4 p.m. No prior authorization is needed for members to access this service. The five NEXTCARE locations are listed in the Provider Directory.

Urgent Care Services

Urgent care means requiring medical attention within a few hours for a condition that is not immediately life-threatening or severe, but for which delay of service would be detrimental.

You are expected to receive urgent care from your PCP Monday through Friday, 8 a.m. to 5 p.m. If your PCP is unable to see you, and your medical need is urgent, call the HealthSelect 24-hour authorization unit at 602-344-8811 for advice.

To Obtain Urgent Care Services

Family Health Centers (FHCs):
Call your PCP during business hours. After hours or holidays, Family Health Centers have an answering service to assist you. If you are unable to reach assistance, call the 24-Hour Authorization Unit, 602-344-8811 or 1-800-552-8808 to be directed to an Urgent Care Center.

Private Physician's Offices:
Call your PCP for instructions. After hours, call the 24-Hour Authorization Unit at 602-344-8111 to be directed to an After-Hours Primary Care Location or Urgent Care Center.

Show Your ID Card.
If you go to the Urgent Care Center before calling the Prior Authorization Unit, ask the Urgent Care Center to call 602-344-8111 or 1-800-552-8808 to get approval before receiving care.

Emergency Services

An emergency is defined as a serious accident or sudden illness that, if not treated immediately, could result in loss of life, limb or body function.

In an emergency, go directly to the nearest hospital or dial 911. You do not need prior authorization from HealthSelect to seek emergency care services. However, if you are admitted to the hospital, you should inform the hospital to call the 24-hour authorization number within 48 hours for prior authorization.

If you go to an emergency room, you will be required to pay a $50 copayment. If you are admitted, the $50 copayment will be waived.

A Guide to Appropriate Use of a Hospital Emergency Room

Good Reasons to Go:

- Chest pain
- Trouble breathing or stopped breathing
- Deep cuts or bleeding that you cannot stop
- Drug overdose or poisoning, or a suicide attempt
- Seizures that are not usual for you
- A major car accident
- When you think you have a broken bone
- Gunshot or stab wound
- If you are pregnant and have severe pain or bleeding with passage of clots
- Serious electric shock or lightning injury
- Stroke symptoms: numbness or paralysis of an arm or leg, suddenly slurred speech, lack of responsiveness, severe headache
- Possible broken neck or back
- Choking which you cannot stop
- When a child older than 2 months has a fever of 101 degrees or higher
- When a child younger than 2 months has a fever of 103 or higher

Do NOT go to the Emergency Room for:

- Routine health care
- Toothache
- Earaches
- Minor persistent headaches
- Body aches, colds, coughing, sore throat and flu
- Hay fever and sinus problems
- Diaper rash
- Chronic back pain or lumbago
- Broken cast
- Teething
- Removal of stitches
- Sunburns or minor cooking burns
- Minor injuries

A hospital emergency room should only be used for true emergencies. If you are not having a true emergency, call your PCP or his/her triage nurse first to discuss your condition and obtain advice. HealthSelect will not be responsible for any charges resulting from non-emergent use of the emergency room. This will be determined by HealthSelect.

Your emergency room copayment ($50) is due at the time services are rendered. If you are admitted to the hospital as a result of your emergency room visit, the $50 copayment will be waived.

Out-of-Area Emergency Services

If you are a HealthSelect member traveling outside of Maricopa County and experience an urgent health problem, it is permissible to use a local physician, urgent care services when appropriate or a hospital emergency room in an emergency situation. Upon arrival in the facility, show the staff your HealthSelect membership card. The message on the reverse side tells the health care providers how to obtain eligibility, authorization and benefit information about you. Failure to properly notify HealthSelect within 48 hours of treatment may result in denial of payment to the provider for these services. HealthSelect will determine if the services are considered urgent or emergent. If you are pregnant and travel outside of Maricopa County within 30 days of your due date, your delivery at a non-network hospital may not be covered.

Urgent care is not covered for full-time students/dependents aged 18-25 who are attending an institution of higher learning outside of Maricopa County. This includes urgent care provided at a student health center for a non-emergency condition. In these cases, where students are temporarily living outside of Maricopa County, only emergency care services will be covered. However, a reimbursement of up to $125.00 per semester will be given to the HealthSelect employee who can furnish evidence of student health insurance coverage purchased for the student/dependent.

Out-of-area providers may ask you to pay your health care bill after receiving services. If approved by Health Select, you will be reimbursed for all costs associated with an emergent/urgent care episode of treatment by presenting a copy of your receipt and any other paperwork the provider had given you as proof of urgent care that has been rendered.

Send the original receipt and paperwork, plus your current address and phone number (home and work) to HealthSelect at:

HealthSelect
Attention: MIHS Health Plans Customer Service Department
2502 E. University, Suite 125
Phoenix, AZ 85034

Once approved, it takes approximately 4-6 weeks to process your reimbursement check. Call Customer Service at 602-344-8760 at the end of the 6 weeks to check processing status if you do not hear from us. If your request for reimbursement is denied, you will receive a formal notification with an explanation of the denial reason.

Please remember that routine, non-emergency and non-urgent care are not covered services from HealthSelect when you are out of HealthSelect's service area (outside Maricopa County). HealthSelect will not reimburse the member for such costs.

Member Copayments

HealthSelect members are responsible for making copayments at the time service is received. It is not accepted practice for providers to bill members for copayments. HealthSelect members should be prepared to make the copayment when they arrive at the service site. Please see the Standard Benefits Summary and Dental Benefits Summary of this Member Handbook/Certificate.

Prescription Coverage

A member may purchase covered prescriptions from a participating pharmacy when ordered by a HealthSelect physician. HealthSelect uses a formulary. If your primary care provider or a specialist physician wants to prescribe a medication that is not included on the formulary, they must contact HealthSelect for prior authorization to prescribe the drug. Non-formulary drugs will only be approved if there is documented medical evidence that the existing formulary drug is not adequate. Only HealthSelect-approved physicians and dentists can write prescriptions for medications in the formulary. All others will be rejected and not authorized by the approved pharmacy's computer system. **This means the member will have to pay for the prescription and will not be reimbursed by HealthSelect.** Written prescriptions can only be filled at the Comprehensive Healthcare Center (CHC) and FHC pharmacies or contracted community pharmacies. See the HealthSelect Provider Directory for the list of approved pharmacies before you fill your prescriptions.

Members must pay a copayment for each prescription or refill. The copayment is due at the time the prescription is received/delivered. The pharmacy has the right to withhold the prescription if the member does not make the required copayment. Each prescription or refill will be limited to no more than a thirty (30) day supply, unless HealthSelect determines that a longer period is warranted.

Members who fill prescriptions at a Family Health Center or the Comprehensive Healthcare Center pharmacy will pay a $2 copayment for a generic prescription and a $5 copayment for a brand name prescription. If the prescription is a maintenance medication, the member can arrange to have a three-month supply delivered to their home by mail for a $4 to $10 copayment ($4 generic, $10 brand name).

The copayments for prescriptions filled at contracted pharmacies (all Fry's Pharmacies and selected United Drug Store locations) will pay a $4 copayment for generic brand prescriptions and a $10 copayment for brand name prescriptions. No prescription home delivery service is available through these pharmacies.

In an emergency situation, out-of-area pharmacies may require the member to pay for a prescription written by an out-of-area emergency room physician. In such cases, the member should obtain a receipt which can then be submitted to HealthSelect for reimbursement. The member will be reimbursed for the actual costs of the prescriptions. Make a copy of the receipt for your records and send the original with a cover letter explaining the circumstances to:

HealthSelect
Attn. MIHS Health Plans Customer Service Department
2502 E. University, Suite 125
Phoenix, AZ 85034

It will take 4-6 weeks to process a reimbursement check. HealthSelect reserves the right to determine the emergent nature of the care before reimbursing the member for prescription expenses. If your request for reimbursement is denied, you will receive a formal notification with an explanation of the reason for the denial.

Covered Benefits

Covered benefits are listed in the HealthSelect *Supplemental Benefits* and *Standard Benefits Summary* sections of this certificate.

Coordination of Benefits

If you or your dependents are entitled to benefits under another group health insurance, HealthSelect will follow the customary coordination of benefits process, which entails billing other health insurance companies for applicable benefits. This means that your primary health insurance plan will pay your claims first. After your benefits under that plan are exhausted, HealthSelect will then pay for your claims for services and benefits covered under HealthSelect.

Denial of Covered Benefits

HealthSelect will not approve or authorize payment in the following situations:

A. The service is not a covered benefit under HealthSelect. Refer to the HealthSelect Standard Benefits Summary Section for covered benefit descriptions and a listing of all health plan limitations and exclusions.

B. The service is not medically necessary. Refer to the Definitions Section in this booklet.

C. The service is provided by a health care professional, institution or other vendor who is not approved by or contracted with HealthSelect and the care or service was not related to an emergency.

D. The service is for routine medical care but was provided in an emergency room or Urgent Care Center (UCC). Emergency Room (ER) services are for emergencies only and Urgent Care Centers (UCC) are for urgent problems only. No other kind or type of care is covered in an Emergency Room or Urgent Care Center.

E. The service is a covered benefit and requires prior authorization before the service is received. However, prior authorization was not obtained by provider from HealthSelect. See page 15 for more information on prior authorization.

Complaint, Grievance and Appeals Process

If you have a question or concern about services received, call the MIHS Health Plans Customer Service Department at 602-344-8760. If your question or concern has not been answered to your satisfaction, call your Personal HealthSelect Specialist at 602-344-8425 for personal attention. If you continue to be dissatisfied about care or services received, (including personnel, facilities, waiting times, claim or treatment denials, etc), you may request for the matter to be handled as a grievance. All grievances must be in writing and sent to:

HealthSelect
Attn: Grievance and Appeals Coordinator
2502 East University, Suite 125
Phoenix, AZ 85034
Fax 602-344-8515

Grievances must be filed no later than 60 days after the date of action, decision, or incident to which they pertain. The Grievance and Appeals Coordinator will acknowledge receipt within five days. The Grievance and Appeals Coordinator will review all circumstances surrounding the issue and respond to the member in writing within 30 days with the proposed resolution.

If applying the standard timeframe for responding to a grievance would seriously jeopardize the enrollee's life or health, or jeopardize the enrollee's ability to regain maximum function, the enrollee may request an expedited decision.

If the request is made or supported by a physician, and the physician indicates applying the standard timeframe would seriously jeopardize the enrollee's health or life, the request is automatically expedited.

If either a verbal or written request is received and approved by HealthSelect for an expedited grievance, the request is to be processed within 72 hours of receipt of the request.

An extension of up to 14 days may be granted, if the enrollee requests the extension or if the health plan needs additional information and the delay is in the interest of the enrollee. The need to receive medical records from a non-contracted provider may be grounds for a 14-day extension. The enrollee must be notified in writing of a delay and the benefit to the enrollee for the delay and the enrollee's right to file a grievance if he or she disagrees with the decision to grant an extension.

Should the member not agree with the Grievance and Appeals Coordinator's determination, a written appeal can be submitted within 30 days from the mailing dates of the grievance decision to:

HealthSelect
Attn: Grievance and Appeals Coordinator
2502 East University, Suite 125
Phoenix, AZ 85034
Fax 602-344-8515

The appeal is sent to the Grievance Committee within HealthSelect for a determination. The Grievance Committee will:

- Review all the records and written material related to the case.
- Interview the member registering the grievance (if appropriate).
- Make the final grievance decision after which the member will be notified in writing of the decision.
- Participate in the decision to grant an extension. If, on the 45th day following the filing of the grievance, it appears additional time is required to review the case, a letter will be sent to the grievant requesting a 30-day extension. All parties must agree to the extension or the final decision will be made within the 60-day time limit.

It is a condition of participation in HealthSelect that the member agrees to initiate and complete the complaint, grievance and appeals process before initiating any arbitration against HealthSelect. The costs of initiating arbitration proceedings shall be paid for by the member. HealthSelect agrees to arbitrate all such matters or disputes arising under this HealthSelect Certificate or based upon contract theory.

Termination by Cause

HealthSelect membership will be terminated when a subscriber or member:

A. Fraudulently uses HealthSelect services or knowingly permits fraudulent use of HealthSelect services by another person.

B. Refuses to pay required copayments.

C. Behaves in a manner that disrupts and/or prevents a health care provider from servicing the subscriber, member and/or other patients in a safe manner. Violent outbursts, verbal and/or physical threats of violence and/or possession of a weapon within the health care setting are examples of some, but not all situations that will result in immediate termination of a HealthSelect member.

D. Was not eligible for medical benefits but was incorrectly enrolled in HealthSelect.

The subscriber and all of his or her dependents will be terminated from the health plan, not just the disruptive member, if any of the above situations occur. Termination of HealthSelect membership requires that your employer (Maricopa County) be notified of the reason for termination.

Termination of Employment

If you leave your employment, you and your dependents may be entitled to continued HealthSelect coverage under federal COBRA provisions. Refer to the HealthSelect Certificate for complete COBRA description. Please contact your employer (Maricopa County Benefits Department) regarding COBRA and continuation of coverage requirements.

Notification of Change

You need to notify Maricopa County Employee Benefits Department at 602-506-1010 and HealthSelect.

- Change your name, address and/or phone number
- Add a dependent through marriage, birth or adoption
- Drop coverage for a dependent due to a divorce or for a dependent who exceeds dependent age limit

The MIHS Health Plans Customer Service Department can be contacted at 602-344-8760 or 1-800-582-8686, TDD 602-344-8789, Monday through Friday, 8 a.m. to 5 p.m. except holidays.

Coverage Under HealthSelect

A. Your spouse and/or your natural and adopted unmarried children can be covered under HealthSelect. Children are considered dependents only through the last day prior to their 19th birthday. If your unmarried child is a full-time student at a college, university, technical school or other institute of learning, he/she can continue his/her coverage through the age of 25 years. You must show proof of the child's continued registration as a full-time student. Handicapped children 19 years or older, who are primarily supported by you and not capable of self-sustaining employment, may remain a "dependent" with periodic proof of disability.

B. **Dependent Care Coverage Out of Maricopa County.** A full-time HealthSelect student aged 19-25 years who is attending a college, university, technical school or institute of higher learning is covered for all medical emergency care while outside of Maricopa County. Although full coverage is not available for these student dependents while attending school outside of Maricopa County, HealthSelect provides an allowance of up to $125 per student per semester with proof of full-time student status and student health insurance purchased. Simply submit a copy of your paid health insurance premium to:

   MIHS Health Plans Customer Service Department
   2502 East University Dr., Suite 125
   Phoenix, AZ 85034
   602-344-8760

   You will receive a check within 8 to 12 weeks of receipt of insurance proof indicating amount you have paid for student health care coverage.

C. Pursuant to state law, dependents who live outside of Maricopa County (the HealthSelect service area), for whom you are responsible for insuring under a court order (legal separation, divorce or custody decree) can be covered under HealthSelect. However, all members may only use HealthSelect-contracted providers within HealthSelect's service area (Maricopa County). Therefore, members and covered dependents are only covered when outside of Maricopa County for a medical emergency. You must provide a copy of the written court decree to Human Resources, Employee Benefits Division, 301 West Jefferson, Phoenix, AZ 85003 and to the HealthSelect Membership Unit, 2502 East University Drive, Phoenix, AZ 85034.

D. **Subrogation/Right of Reimbursement.** As a condition to receiving benefits under this Plan, Covered Person(s) agree to transfer to the Plan their rights to recover damages to the extent of benefits paid by the Plan when an Injury or Illness occurs through the act or omission of another person. If a Covered Person(s) receives payment from another person or business entity on account of an Injury or Illness, Covered Person(s) agrees to reimburse the Plan to the full extent of benefits paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to the Plan regardless of whether it is actually signed. It is only necessary that the Injury or Illness occur through the act or omission of another person. The Plan's rights of full recovery may be from a third party, any liability or other insurance covering the third party, the Covered Person(s)' own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault or school insurance coverages which are paid or payable. The Plan may enforce its reimbursement rights by requiring the Covered Person(s) to assert a claim to any of the foregoing coverages to which he/she may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Plan representatives. The Plan shall not be required to pay any portion of Covered Person(s)' attorneys' fees or other costs associated with a lawsuit.

E. **Recovery of Payments.** The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. in error;
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. in anticipation of obtaining a recovery in subrogation if a Covered Person fails to comply with the provision of Paragraph C above; or
6. pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan holder to pay benefits under this Plan in any such instance.

Such deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to such Covered Person.

COBRA Coverage

On April 7, 1986 a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the new law. **(Both you and your spouse should take the time to read this notice carefully.)**

If you are an employee of Maricopa County covered by the county's medical, employee assistance program, dental or health care reimbursement account you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by Maricopa County's group health plans you have the right to choose this continuation coverage; if you lose your group health coverage under the medical employee assistance program, dental or health care reimbursement account for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by Maricopa County's group health plans, he or she has the right to continuation coverage if group health coverage under the medical, employee assistance program, dental or health care reimbursement account for any of the following five reasons:

1. The death of a parent;
2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
3. A parent's divorce or legal separation;
4. A parent becomes entitled to Medicare;
5. The dependent child ceases to be a "dependent child" under the employers' group health plans.

Under the law, the employee or a family member has the responsibility to inform the plan administrator, Maricopa County Human Resources, within 60 days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. Maricopa County has the responsibility to notify the COBRA Administrator, Administrative Enterprises, Inc., of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the COBRA Administrator, Administrative Enterprises, Inc., is notified that one of these events has happened, the COBRA Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above, or the date notice of your election rights is sent to you whichever is later, to inform the COBRA Administrator, Administrative Enterprises, Inc., that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance will end.

If you choose continuation of coverage, Maricopa County is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. The new law requires that you be afforded the opportunity to maintain continuation coverage for three years unless you lost group health coverage because of a termination of employment or a reduction in hours. In that case, the required continuation coverage period is 18 months. This 18 months may be extended to 36 months if other events (such as death, divorce, legal separation or Medicare entitlement) occur during that 18-month period.

The 18 months may be extended to 29 months if an individual is determined (under Title II or XVI of the Social Security Act) to have a disability and the COBRA Administrator, Administrative Enterprises, Inc., is notified of that determination within 60 days. The affected individual must also notify the COBRA Administrator, Administrative Enterprises, Inc., within 30 days of any final determination that the individual no longer has a disability. In no event, will continuation coverage, last beyond three years from the date of the event that originally made a qualifying beneficiary eligible to elect coverage.

However, the law also provides that your continuation coverage may be terminated for any of the following five reasons:

1. Employers no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered by another group plan, unless the plan contains any exclusions or limitations with respect to any pre-existing condition you or your covered dependents may have;
4. You become entitled to Medicare;
5. You extend coverage for up to 29 months due to your disability and there has been a final determination that you no longer have a disability.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you may have to pay all or part of the premium for your continuation coverage. There is a grace period of at least 30 days for payment of the regularly scheduled premium. (The law also says that, at the end of the 18-month or three-year continuation coverage period, you must be allowed to enroll in an individual conversion health plan provided under Maricopa County's health plans, if the contract provides for a conversion option.).

This law applies to Maricopa County beginning on April 07, 1986. If you have any questions about the law, please contact:

Administrative Enterprises, Inc.
Maricopa County COBRA Program
3404 West Cheryl Drive, Suite 280
Phoenix, AZ 85051-9588
602-789-1170

HIPAA

On August 21, 1996, a new federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [Public Law 104-191], was enacted. The HIPAA changed the continuation coverage requirements under COBRA that apply to the Maricopa County plans. Generally, effective January 1, 1997, (regardless of whether the qualifying event occurred before, on or after that date) under COBRA, if the qualifying event is a termination or reduction in hours of employment, affected qualified beneficiaries are entitled to continue coverage for up to 18 months after the qualifying event, subject to timely premium payments. Before HIPAA, this 18-month period could be extended for up to 11 months (for a total COBRA coverage period of up to 29 months from the initial qualifying event) if an individual was determined under the Social Security Act to have a disability at the time of the qualifying event and if the plan administrator was notified of that disability determination within 60 days of the determination and before the end of the original 18-month period.

Under the new law, if a qualified beneficiary is determined to have a disability under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The individual with a disability can be a covered employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notice requirements in a timely fashion.

Furthermore, a child that is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the HealthSelect Plan and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Maricopa County Human Resources or AEI of the birth or adoption.

In addition to changing some of the COBRA requirements, HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally not effective until Plan Years beginning after June 30, 1997. HIPAA coordinates COBRA coverage with these new limits as follows:

Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be terminated due to your new health plan coverage. However, if the other plan's pre-existing condition limitation rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Maricopa County Cafeteria Plan may terminate your COBRA coverage.

If you have any questions about the COBRA law, please contact Maricopa County Human Resources, (Employee Benefits) 301 West Jefferson Street, Phoenix, AZ 85003, or its agent, Administrative Enterprises, Inc., Maricopa County COBRA Program, 3034 West Cheryl Drive, Suite 280, Phoenix, AZ 85051. Also, if you have changed marital status, or you or your spouse have changed address, please notify Maricopa County Human Resources at the above address, within 31 days.

Prior Authorization and In-Plan Network Changes

All care received by HealthSelect members must be a covered service and be provided by approved or contracted physicians, institutions, agencies and vendors. This rule is waived only in the case of an emergency. Members may receive emergency care from any appropriate provider anywhere in the world.

Please see *The Standard and Supplemental Benefits Summary* Chart for the specific services/care which require prior authorization from HealthSelect and those services which do not require prior authorization. Covered services that require prior authorization will only be covered when prior authorization is received from HealthSelect before services are rendered.

HealthSelect members who obtain routine, non-emergency care outside the approved provider network will be financially responsible for that care. Members may only use non-approved providers when in a medical emergency. In all other cases, you must obtain prior authorization. HealthSelect reserves the right to determine what constitutes medically necessary, emergency care according to descriptions included in this certificate. All care delivered in an emergency room will result in a $50 copayment. The $50 copayment will be waived if admitted to the hospital.

HealthSelect reserves the right to change the authorization status of health care services upon 30 days written notice to its subscribers.

Provider Network

HealthSelect now offers you a wider Provider Network than was available in previous years. Members may call MIHS Health Plans Customer Service Department to choose a Primary Care Physician if not indicated on the enrollment form. Members within a family may choose different Primary Care Physicians. **Members may change PCPs by notifying the MIHS Health Plans Customer Service Department at 602-344-8760 or 1-800-582-8686).** All PCP changes will become effective the first day of the following month from the member's date of request. HealthSelect will confirm the member's PCP change in writing to the subscriber. You may change, for no cause, no more than four times per contract year.

Member Copayments

HealthSelect members are responsible for making copayments at the time service is received. It is not an accepted practice for providers to bill members for copayments. HealthSelect members should be prepared to make the copayment when they arrive at the service site. **Office visit copayments apply to any encounter, including an Urgent Care Center visit in which the member is cared for by a Physician, Nurse Practitioner, Physician Assistant, Dentist, Audiologist, Audiology Technician, Optometrist or Optometry Technician. HealthSelect requires copayments for the following services:**

SERVICE MODALITY	COPAYMENT SUMMARY
Primary Care Physician Office Visit	$5
Prenatal Care Office Visit	$0
Specialty Care Physician Office Visit	$5
Audiologist Office Visit	$5
Emergency Room Services (If the member is admitted to the hospital directly from the Emergency Room, the $50 copayment is waived.)	$50
Urgent Care Visit	$5
Dental Office Visits (plus 20% of service costs for covered services when applicable)	$5
Outpatient Therapy	$5
Outpatient Rehabilitation	$5
Prescription Medications	$2 – $10 (see chart below)
Chiropractic Services	$10
Alternative Medicine	$5
Weight Management	$10
Lab Services, Mammograms, X-rays	$0
Colorectal Exam, Pap Smear Exam, Prostate Cancer Screening	$0
Adult Immunizations without PCP encounter	$0
Home Health Visits	$0

Comparison of Pharmacy Copays	Drug Type[1]	Cost at Fry's Pharmacy	Cost at FHC Pharmacy[2]
	Generic (Formulary)	$4	$2
	Brand (Formulary)	$10	$5

[1]Non-formulary drugs require prior authorization from HealthSelect.

[2]Prescription home delivery service available only from FHC and CHC pharmacies. There is a copay of $4 (generic) and $10 (brand) per three-month supply of maintenance medication only.

See the following *Supplemental Benefits* and *Standard Benefits Summary* Chart for exact copay amounts.

Visits made solely for all routine immunizations, x-rays, or lab tests that are not associated with an encounter with a physician do not require a copayment (see *Standard Benefits Summary* Chart).

Supplemental Benefits Summary

SUPPLEMENTAL BENEFITS	COVERAGE STATUS	PRIOR AUTHOR. REQUIRED?	HOW TO ACCESS SERVICES
Student Health Insurance Allowance	HealthSelect will pay an allowance of up to $125 per semester toward the premium cost for health insurance for a full-time student covered under HealthSelect and attending an institute of higher learning outside the Maricopa County service area.	No	To obtain allowance, member must submit proof of insurance coverage and premium payment; proof of full-time student status at an educational facility outside of Maricopa County also required.
Lasik Surgery	Available to eligible candidates at a discounted price of $875 per eye surgery per contract year. Must be performed by a HealthSelect-contracted Lasik Surgery provider. Repeat surgeries are not covered.	No	Direct access, PCP referral or prior authorization not required.
WELLNESS INCENTIVES			
Health Club Attendance	Members who pay a health club membership at any health/fitness club and work out at least 8 times per month are eligible to receive a $75 incentive award every 6 months.	No	Use your Health Club Certificate (on page 37) to have your health club certify your attendance of 8 times per month. Submit completed form at the end of 6 months to obtain your award.
Childhood Immunizations	Members who obtain recommended immunizations for their small children (5 years old or younger) are eligible to receive a $25 gift certificate.	No	When your child's immunizations are completed for his/her birth year, have the physician sign and date the Immunization Certificate (on page 41) and submit to HealthSelect to obtain your $25 gift certificate for local goods/ services.

**See additional description of benefits on pages 25-27.*

Supplemental Benefits Summary

SUPPLEMENTAL BENEFITS	COVERAGE STATUS	PRIOR AUTHOR. REQUIRED?	HOW TO ACCESS SERVICES
Wellness Screenings	Members who complete the following wellness screenings from your Health Select-contracted PCP are eligible to receive a $25 gift certificate: • Pap smear test for women age 18 and older. • Mammogram for women age 40 and older. • Annual physical exam for men age 40 and older. (See Health Education section on page 24 for a $25 reimbursement on special class completion.)	No	Submit proof of the completion of these wellness activities to HealthSelect to receive a $25 gift certificate for each activity. Use the Wellness Certificate (on page 39) and submit to HealthSelect to obtain your gift(s); limited to only one gift award per screening type per benefit year. All required documentation must be submitted to: MIHS Health Plans Customer Service Department 2502 East University, Suite 125 Phoenix, AZ 85034 602-344-8760 or 1-800-582-8686
Chiropractic Care	• Initial assessment plus seven visits per year. • Additional chiropractic services covered only if medically necessary and must be prior authorized. • $10 copayment per office visit. Limit of two x-rays per contract year. • Member is responsible for all charges beyond covered benefit limitation.	No	Direct access. PCP referral **not** required. Visits beyond six will require PCP referral and HealthSelect prior authorization.
Alternative Medicine*	• Initial assessment plus six visits per year. • $60 credit for supplies prescribed by alternative medicine provider (*see notes on how to obtain credit). • $5 copayment per office visit. • Member is responsible for charges beyond covered benefit limitation.	No	Direct access. PCP referral **not** required.

**See additional description of benefits on pages 25-27.*

Supplemental Benefits Summary

SUPPLEMENTAL BENEFITS	COVERAGE STATUS	PRIOR AUTHOR. REQUIRED?	HOW TO ACCESS SERVICES
Adult Dental	Diagnostic and preventive treatment and some restorative services (see Table of Dental Benefits). $5 copayment per office visit. 20% service fee on some services (see Dental Benefits). Member will be responsible for charges beyond covered benefit limitation.	No	Direct access. PCP referral **not** required.
Weight Loss Counseling*	Initial assessment plus five visits. $10 copayment per office visit (see notes regarding vouchers). Member is responsible for charges beyond covered weight loss benefit limitation. Additional counseling related to a medical condition is covered with PCP referral.	No	Direct access. PCP referral **not** required. Call Customer Service to obtain vouchers.

Note: Chiropractic Care, Alternative Medicine, Dental, Weight Loss/Nutrition Counseling Services and Lasik Surgery are available from only HealthSelect-contracted providers that are listed in the HS Provider Directory. These are subject to availability. Prescriptions ordered by providers must be in HealthSelect formulary.

Standard Benefits Summary

STANDARD BENEFITS	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Office/Clinic Visit Primary Care Physician/Nurse Practitioner/ Physician Assistant Services	$5 copayment per visit – covered.	No
Specialist Physician Services	$5 copayment per visit – covered.	No (except for infertility specialist, pain management specialist, podiatrist and allergist outside of the FHCs and CHC).

**See additional description of benefits on pages 25-27.*

Standard Benefits Summary

STANDARD BENEFITS	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Well-Child Care, Children's Periodic Health Exams	$5 copayment per visit – COVERED.	No
Physician Visits to Hospital, Skilled Care Facility or Rehab Facility	$0 copayment – COVERED.	No
Hearing Exams	$5 copayment per visit – COVERED.	No
Hearing Aids	$500 allowance per contract year – COVERED.	No
Vision Exams	(See Sight Care Copayment) Available through Sight Care.	No
Eye Glasses and Contact Lenses	(See Sight Care Copayment) Available through Sight Care.	No
Eye Wear Following Cataract Surgery	COVERED.	No
Routine Pediatric Immunizations, Adult Immunizations (Flu, Pneumovax and Hepatitis B for high risk)	None if obtaining immunization only. $5 copayment if combined with doctor visit – COVERED.	No
Immunizations for Foreign Travel	NOT COVERED.	N/A
Routine Injectables on Formulary	$5 copayment per visit – COVERED.	No
Pediatric Dental Services	See Pediatric Dental Benefits section; $5 copay per office visit, **$1200 annual cap**. Some services require a 20% service charge in addition to the dental visit copayment – COVERED.	No

**See additional description of benefits on pages 25-27.*

Standard Benefits Summary

STANDARD BENEFITS	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Adult Dental Services	See Adult Dental Benefits Section; $5 copayment per office visit. No dollar limit except for limit on scope of services. Some services require a 20% service charge in addition to the $5 dental office visit copayment – COVERED.	No
Surgical Services: Inpatient or Outpatient and Anesthesia (elective abortion included)	$0 copayment – COVERED.	Yes
Laboratory and Radiology (X-ray) Services	$0 copayment – COVERED.	No (if in network). Yes (if out of network).
Rehabilitation Services Inpatient, Home Care	$0 copayment – COVERED.	Yes
Outpatient Rehabilitation Services	$5 copayment per office visit.	Yes
Physical Therapy, Speech Therapy, Occupational Therapy	COVERED up to 60 days; $5 copayment.	Yes
Psychiatric, Mental Health or Behavioral Health Services	NOT COVERED. (Covered by Maricopa County – please call the county's Behavioral Health Provider at 1-800-343-2183); drugs prescribed by the Behavioral Health Provider are covered but require prior authorization by HealthSelect.	Not applicable
Medical Social Worker, Health Education Services	$0 copayment – COVERED.	No
Emergency Ambulance Transport*	$0 copayment – COVERED.	No
Non-Emergency Transport	NOT COVERED.	Not applicable

**See additional description of benefits on pages 25-27.*

Standard Benefits Summary

STANDARD BENEFITS	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Durable Medical Equipment (DME)	$0 copayment – COVERED. Limit $2,000 per contract year.	Yes
External Prosthetics*	$0 copayment – COVERED. Limit $2,000 per contract year.	Yes
Orthotics*	$0 copayment – COVERED. Limit $2,000 per contract year.	Yes
Medical Supplies (Home Health)	Covered, when medically necessary, $0 copayment.	Yes
Blood and Blood Products	$0 copayment – COVERED.	No
Nuclear Medicine	$0 copayment – COVERED.	No
Organ Transplants*	$0 copayment – COVERED if not experimental or investigational (must meet HealthSelect Plan criteria and be prior authorized).	Yes
Immunosuppressive Drugs*	$2 – $10 copayment per prescription (within formulary); must meet HealthSelect criteria and be prior authorized. (See page 16 on copays at FHCs vs. Fry's and United Drugs.)	Yes
Chemotherapy	$0 copayment – COVERED.	Yes
Dialysis	$0 copayment – COVERED.	Yes
Podiatry Services*	NOT COVERED for routine foot care; COVERED if medically necessary; $5 copayment per visit.	Yes
Home Health Agency Skilled Services*	COVERED through a Medicare-certified Home Health Agency – $0 copayment.	Yes

**See additional description of benefits on pages 25-27.*

Standard Benefits Summary

STANDARD BENEFITS	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Hospice Services	$0 copayment – COVERED by a Medicare-certified Hospice.	Yes
Mammograms	$0 copayment – COVERED.	No
Prostate Cancer Screening	$0 copayment – COVERED.	No
Pelvic Exam and/or Pap Smears	$5 copayment per office visit; $0 copay for exam – COVERED; screening limit one per year.	No
Prenatal Care, Delivery	$0 per prenatal care visit – COVERED; hospitalization must be authorized separately; $0 copayment for delivery.	Yes (prior global authorization needed for prenatal visit package)
Family Planning*	$5 copayment per office visit. No more than one Norplant implant or removal in five years – COVERED.	No
Allergy Testing and Treatment	$5 copayment per office visit – COVERED.	Yes (if outside HS network)
Second Medical Opinion	$10 copay; COVERED when medically appropriate.	Yes (must be approved by HealthSelect Medical Director)
Inpatient, Acute, Medical Hospital Care	$0 copayment – COVERED.	Yes
Outpatient Medical Hospital Services	$0 copayment – COVERED.	Yes
Skilled Care Facility Services	$0 copayment – COVERED up to 20 days per illness.	Yes

**See additional description of benefits on pages 25-27.*

Standard Benefits Summary

STANDARD BENEFITS	COVERAGE STATUS/COPAYMENT	PRIOR AUTHOR. REQUIRED?
Infertility Office Visits and Medical Work-Up (to rule out associated medical conditions that may be covered for treatment)	$5 copayment per office visit – COVERED.	Yes
Infertility Drugs, Injections, Supplies and Treatment	NOT COVERED.	Not applicable
Emergency Room Services*	COVERED with a $50 copayment; copayment waived upon hospital admission.	Yes (plan must be notified upon arrival at the emergency facility or within 48 hours)
Obesity Treatments Including Surgery	NOT COVERED – (see Exclusions Section).	Not applicable
Medical Urgent Care Center Services	$5 copayment per visit – COVERED.	Yes
Health Education*	COVERED; Smoking Cessation class at MMC — $5 copayment. Reimbursement of up to $25 for Asthma Education, Hypertension Education, Diabetes Education, Smoking Cessation and Health Education classes received from non-profit organizations.	No
Prescription Medications* (including over-the-counter medications on formulary)	$2 – $10 copayment for each prescription; COVERED. (See Pharmacy Copay grid on page 16.)	No (if formulary) Yes (if non-formulary or if prescription requires prior authorization)
Prescription Home Delivery Service	$4 – $10 copayment for each 3-month supply per prescription; covered for maintenance medicines at FHC and CHC pharmacies only. (See Pharmacy Copay Grid on page 16.)	No (if formulary) Yes (if non-formulary or if prescription requires prior authorization)

**See additional description of benefits on pages 25-27.*

Conditions of Participation and Benefit Coverage

In order for HealthSelect to pay for a medical, dental or pharmacy benefit, these three conditions of participation must be met by the provider and/or member:

A. The provider must be approved by HealthSelect, except in an emergency situation. In the latter case, any emergency provider can be used without prior approval or authorization from the health plan.

   Emergency care provided by a non-contracted physician, urgent care center or emergency room will be paid at HealthSelect's Standard Contract rates or at provider's billed charges, whichever is lower. If HealthSelect's Standard payment is lower than billed charges, the HealthSelect member may be billed by the provider for the difference.

B. The care and/or service must be Medically Necessary or meet the following definition of Medical Necessity:

   - Arizona Administrative Code R9-22-101 (69) defines medically necessary as ". . . those covered services provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law to:
   - "Prevent disease, disability and other adverse health conditions or their progression, or
   - To prolong life."

   Medical necessity is also established if:

   - The disease or condition considered for treatment is one in which the effectiveness of the proposed therapy has been demonstrated and documented,
   - The stage of disease or condition is such that therapy can affect the outcome in a positive manner and/or
   - The recipient of care has no other conditions which substantially reduce the potential for successful recovery.

C. The care, service and/or treatment must be within the accepted standards of care or practice within the health care community, be a reasonable method for treating the member's health problem(s) and not be experimental or investigational in nature. Medical research findings, government approval and/or professional standards of practice are used by HealthSelect to apply, define and justify this condition of participation.

Additional Description of Benefits

Air Ambulance — Air ambulance that does not originate from the scene of an accident requires prior authorization. Air ambulance from one facility to another facility also requires prior authorization.

Alternative Medicine — Benefits include only the following: Acupuncture, Homeopathy and Osteopathic Manipulation/Craniosacral Therapy, when provided by a participating provider. The only Alternative Medicine Supplies that will be covered are those described in the Definition Section. Supplies must be ordered by the contracted Alternative Medicine Provider. Members must send a copy of the doctor's order/prescription along with the paid receipt for the supply item(s) to MIHS Health Plans Customer Service Department in order to be reimbursed.

Emergency Room Services — The $50 copayment is waived if the HealthSelect member is admitted to a hospital directly from the emergency room. Admission to a hospital's observation unit does not constitute an admission to the hospital and the $50 copayment must be paid by the member.

Family Planning Services

Voluntary family planning services include physical exams, office visits and routine laboratory tests. Contraceptive devices/drugs that are covered include Norplant, IUDs, Depo-Provera, diaphragms and birth control pills. Condoms and spermicidal foam are not covered as they are over-the-counter birth control items. Voluntary surgical sterilization for men and women is covered, but reversal of a sterilization technique is not covered.

Infertility services are covered for office visits, examinations, laparoscopy and hysterosalpingogram but not for subsequent treatments or medications.

HealthSelect does not cover in-vitro fertilization, artificial insemination and gamete transfer or infertility medications, injections or supplies.

Health Education Services

Health Education classes (in Smoking Cessation, Asthma Education, Diabetes Education and Hypertension only) that are presented by non-profit health agencies and institutions in Maricopa County will be covered by HealthSelect. The member must pay the fees for the program. HealthSelect will reimburse the member for the registration fees up to $25 upon proof of payment and successful completion of the program. A Smoking Cessation class is offered by the MMC Cardiac Rehab Clinic upon PCP referral. A $5 copayment applies.

Hepatitis B Immunization

Members who work in health care facilities and perform direct patient care or work with body fluids are eligible for this immunization through their employer. All other at risk members can receive this immunization from their primary care physician and it will be paid for by HealthSelect.

Home Health Agency Skilled Services

Only those home health care services provided by a Medicare-certified Home Health Agency are eligible for coverage under HealthSelect. Attendant, homemaker and related non-health care services available through home health agencies or community-based agencies for assistance in activities of daily living in the home are not covered. Any service that is custodial in nature or designed to maintain the patient's current health and functional status in the home are not covered by HealthSelect.

Immunosuppressive Drugs

HealthSelect covers the cost of immunosuppressive drugs on formulary if it is prior authorized by HealthSelect and meets medical necessity criteria. The member is responsible for any applicable copayments.

Organ Transplants

Cornea, kidney, heart, lung, liver and bone marrow transplants will be covered by HealthSelect if the member meets all transplant candidate criteria and the procedure is not deemed experimental or investigational within the medical community and by federal and/or professional agencies, institutions or other standard-setting bodies. All conditions of participation apply to organ transplants.

HealthSelect does not cover the cost of donor searches.

HealthSelect will cover all reasonable and necessary organ bank fees. HealthSelect reserves the right to determine what is medically reasonable and necessary.

Podiatry Services

Routine foot care services are not covered by HealthSelect. The member must have a medically diagnosed health problem that, if left untreated, would result in loss of function of the lower limbs, in order for podiatry services to be covered.

Prescription Medications	HealthSelect will cover only those prescriptions which are included in MIHS Health Plans' formulary or list of approved medications that are ordered by the member's primary care physician, nurse practitioner, physician assistant or a HealthSelect-approved specialist provider. HealthSelect uses a formulary of medications or list of approved medications. Non-formulary drugs require prior authorization from HealthSelect. If a drug is available generically, the generic must be dispensed. The brand is listed for reference purposes only. Prescriptions are always filled for a 30-day supply. A separate copayment is charged for each prescription and refill. A three-month supply of maintenance prescription drugs only can be made available through home delivery by mail when arranged through a Family Health Center pharmacy. This service is not available at Fry's or United Drug stores. A copay of $4 generic or $10 brand per three-month supply applies. The copayment of $2 – $10 per prescription applies. Prescriptions must be filled at HealthSelect-approved pharmacies, except for emergencies outside of Maricopa County. All prescriptions on formulary are covered upon hospital discharge or emergency room discharge even when written by non-contracted hospital/ER physician. Over-the-counter drugs listed on MIHS Health Plans formulary are covered. When prescriptions are filled at a pharmacy located within a Family Health Center, they may be delivered to your home upon prior arrangement with pharmacist at no additional cost.
Prosthetic and Orthotic Supplies	HealthSelect sets a $2000 limit for each benefit per contract year. Requests must meet medically necessary criteria.
Weight-Loss Counseling	Members need to obtain vouchers from MIHS Health Plans Customer Service Department 602-344-8760. Vouchers must be presented to Nutritionist at time of service (initial assessment plus three visits). Please note: Only one set of vouchers (four) will be issued for each member. Appointments can be made directly with Nutritionist at 602-344-1015. A $10 copay applies.

Exclusions and Limitations

Any services not provided or arranged by an approved contracted physician or health care provider, or approved in advance by MIHS Health Plans or HealthSelect (except for urgent care services outside of Maricopa County or emergency care at any location) **are not covered by HealthSelect.** The **conditions of participation** previously described in this HealthSelect Certificate booklet must be fulfilled in order for HealthSelect to cover a benefit, service or health care.

The following services are not covered by HealthSelect

A. Christian Science practitioners' services.

B. Cosmetic surgery.

C. Custodial or maintenance care.

D. Health care and delivery costs for a natural mother whose infant is being adopted by a HealthSelect subscriber are not covered. The infant is covered for the first 30 days of life and must be enrolled in HealthSelect for coverage to continue.

E. Care of a subscriber's newborn dependent is not covered after 30 days of life unless the child has been enrolled in HealthSelect. Any lapse in coverage between the 30th day of life and the effective enrollment date with HealthSelect is the subscriber's responsibility.

F. Experimental or investigational treatments including organ transplants, as defined by the Food and Drug Administration (FDA), community medical standards and other standard-setting and regulatory agencies and organizations.

G. Routine foot care by a podiatrist for adults.

H. Homemaker, attendant care, personal care and chore services not provided under Medicare Home Health Care rules and regulations.

I. Hospice services not provided through a Medicare-certified hospice.

J. Immunizations for foreign travel.

K. Factor IIX injections.

L. Full-time nursing care in the home and private-duty nursing in a health care institution. Home nursing care must meet HCFA Home Health rules and regulations.

M. Obesity treatments including surgery (gastric stapling).

N. Orthopedic shoes unless they are part of a leg brace and they are included in an approved orthopedist's charges.

O. Personal convenience items including, but not limited to, a telephone or television in a member's room at a hospital or skilled care facility.

P. Physical examinations, check-ups and laboratory tests that are performed to obtain insurance, a job, a pilot's license, insurance payments or to certify ability to participate in organized athletic events or for school admission.

Q. Reversal of voluntarily induced sterilization.

R. Services performed by immediate relatives or members of the member's family.

S. Routine health care services, convalescent services, home health services, rehabilitation services and any other non-emergency care or service provided outside of Maricopa County, unless prior authorized by HealthSelect.

T. Transsexual surgery and any therapy in preparation for or following such surgery.

U. Penile implants.

V. Biofeedback for conditions other than muscle re-education.

W. Breast reduction, enlargement or enhancement except for reconstructive surgery post mastectomy.

X. More than one contraceptive drug implant or more than one removal of the contraceptive drug implant in any five (5) year period, unless the procedure is determined to be medically necessary and approved by HealthSelect.

Y. Infertility treatment and medications.

Z. Treatment of sexual dysfunction including Erect Aid for impotence.

AA. Services and treatments for learning disorders, mental retardation, developmental disabilities and behavioral problems.

BB. Circumcision, except for newborns within 30 days of birth or related to organic disease.

CC. Services or items furnished gratuitously or for which charges are not usually made.

DD. Services provided in a sanitarium for tuberculosis. This exclusion applies to court-ordered incarceration in a tuberculosis treatment facility.

EE. Medical services provided to a member, or eligible dependent, who is an inmate of, or in the custody of a public institution.

FF. Psychiatric, mental health and behavioral health care and services are not covered by HealthSelect. (Maricopa County covers this for all employees through CIGNA Behavioral Health. Call 1-800-343-2183 to access Behavioral Health Services.)

GG. Physical and occupational therapy and/or speech pathology services prescribed as a maintenance regimen are not covered.

HH. Pulmonary rehabilitation.

II. Augmentative communication device.

JJ. Cochlear device implant.

KK. Aquatic therapy.

LL. Implantable artificial urinary sphincter.

MM. Additional chiropractic visits beyond benefit limit which have not been prior authorized by HealthSelect are not covered.

Prescription Exclusions and Limitations

A. Prescriptions must be in formulary and are only covered for a 30-day supply or 100-unit supply at a time (not to exceed 30 days). Amounts greater than this require approval from HealthSelect. Prescriptions ordered by an emergency room or urgent care center physician will only be covered for a five (5) day supply. It is expected that the patient will obtain a follow-up appointment with the Primary Care Physician and excluded from this five (5) day supply rule will be antibiotics prescribed by an emergency room or urgent care center.

B. Any prescription refilled in excess of the physician's order or refills dispensed more than one year after the original prescription date are not covered.

C. Prescriptions that are not listed in the current MIHS Health Plans drug formulary will not be covered or reimbursed by HealthSelect.

D. Prescriptions that are not ordered by an approved physician or dentist will not be covered or reimbursed by HealthSelect.

E. Prescriptions that are not filled at a HealthSelect-approved pharmacy will not be covered or reimbursed by HealthSelect.

F. Experimental or investigational drugs as designated by the Food and Drug Administration and/or HCFA are not covered.

G. All physician requests for non-formulary drugs must be submitted to HealthSelect's Medical Services Department by the provider. The provider must submit reasonable evidence that the formulary drug was not effective.

H. Behavioral Health Services are not covered by HealthSelect. These services can be obtained through MCC, a separate entity contracted with Maricopa County. Call 1-800-289-8167 to request an authorization to be seen by a contracted behavioral health provider within MCC's network. HealthSelect covers behavioral health medications only when prior authorized by HealthSelect and written by an MCC-approved psychiatrist.

I. Therapeutic devices or appliances, support garments and other non-medical substances are not covered. Insulin syringes and chemotest strips are covered for insulin and non-insulin dependent diabetics only. One glucometer per lifetime is covered for diabetics.

J. Charges for administration or injection of any drug are not covered and are the responsibility of member. (Injections given by home health services are covered).

K. Drugs to treat impotence are not covered.

Pediatric Dental Benefits

There is always a $5 dental office visit copayment. In addition, some services have a 20% service charge. **The $1200 annual limit on expenses applies to children's dental services only.** The following dental services are covered for HealthSelect enrolled children:

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
DIAGNOSTIC SERVICES	
Complete oral evaluation[1]	No charge
Periodic oral evaluation	No charge
Limited oral evaluation – problem-focused	No charge
X-rays – intraoral complete series including bite-wings	No charge
X-rays – intraoral – periapical – first film	No charge
X-rays – each additional film	No charge
X-rays – intraoral – occlusal film	No charge
X-rays – extraoral – first film	No charge
X-rays – extraoral – each additional film	No charge
X-rays – bitewing – single film	No charge
X-rays – bite-wings – two films	No charge
X-rays – bite-wings – four films	No charge
X-rays – panoramic film	No charge
Pulp vitality test	No charge
PREVENTIVE DENTISTRY	
Preventive education, including nutritional counseling, as part of an examination or treatment	No charge
Teeth cleaning (once every six months or as indicated by EPSDT guidelines for children)	No charge
Fluoride application	No charge
Topical application of sealant	No charge
RESTORATIVE DENTISTRY	
Amalgam restorations – primary	
One surface	$10
Two surfaces	$13
Three surfaces	$15
Four or more surfaces	$18
Amalgam restorative – permanent	
One surface	$11
Two surfaces	$14
Three surfaces	$17
Four or more surfaces	$20

Pediatric Dental Benefits

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
Filling	
Resin – one surface – anterior	$13
Resin – two surfaces – anterior	$17
Resin – three surfaces – anterior	$21
Resin – four or more surfaces involving incisal angle	$23
Pin retention under filling (per tooth)	$10
Unspecified restorative procedure (acid etch)	$10
Sedative filling	$9
Silicate cement (per restoration)	$8
Crown	
Stainless steel primary	$24
Stainless steel permanent	$29
Stainless steel with resin window	$32
ENDODONTICS	
Root canal therapy – anterior	$63
Root canal – bicuspid	$73
Root canal – molar	$103
Pulp cap – direct or indirect	No charge
PERIODONTICS	
Gingival curettage (per quadrant)	$34
Gingivoplasty (per quadrant)	$68
Gingival flap (per quadrant)	$51
Osseous surgery (per quadrant)	$140
Gingivectomy (per tooth – fewer than six teeth)	$21
Scaling and root planing (per quadrant)	$23
REPAIRS	
Re-cement inlay, crown or bridge	$9
ORAL SURGERY	
Routine extraction	
One tooth	$13
Each additional tooth	$12
Surgical extraction of erupted tooth	$24

Pediatric Dental Benefits

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
ORAL SURGERY (CONT.)	
Removal of impacted tooth	
Soft tissue	$28
Partially bony impaction	$36
Completely bony	$44
Surgical removal of residual root	$28
Biopsy of oral tissue – hard	$28
Biopsy of oral tissue – soft	$36
OTHER SERVICES	
Analgesia	$7
Palliative emergency treatment of dental pain – mixed procedure	No charge
Emergency care (out of area) see HealthSelect Dental Limitations (page 35)**	Member pays all costs beyond $50.

HealthSelect covers pediatric dental services for children from birth through age 18 years. Pediatric Dental coverage ends on the 19th birthday, even if the subscriber enrolls the child as a full-time student. HealthSelect members may seek dental care without referral by the primary care physician. The dental provider will obtain necessary authorizations for treatment of the child as needed.

Coverage of tooth replacements may be available to some children. The tooth being replaced must have been a permanent one. Coverage is determined on a case-by-case basis by HealthSelect.

HealthSelect does not cover services that are specifically excluded from coverage even when a HealthSelect dentist makes the referral. These services will become member's financial responsibility.

**Need authorization from HealthSelect.

[1]Once per contract year.

[2]Routine cleaning once each coverage year.

Pediatric Dental Exclusions and Limitations

HealthSelect does not provide coverage for prosthetics or prosthetic repairs. Emergency treatment secondary to traumatic injury to the teeth, gums and/or bone is available within the hospital or outpatient setting. Member may be responsible for payment of follow-up treatments not covered in the above benefit list or for expenses that exceed the $1200 annual limit on expenses for children's dental services.

Dental services for children must meet the Conditions of Participation described previously in this HealthSelect Certificate. See other Exclusions and Limitations (Pediatric and Adult Dental Services) Section.

There is always a $5 dental office visit copayment. In addition, some services require a 20% service charge. There is a $1200 annual limit.

Adult Dental Benefits

There is always a $5 dental office copayment. In addition, some services require a 20% service charge. There is no annual limit. The following dental services are covered for HealthSelect enrolled adults:

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
DIAGNOSTIC SERVICES	
Comprehensive oral exam[1]	No charge
Periodic oral exam (once per contract year)	No charge
Limited oral evaluation – problem-focused	No charge
X-rays – full mouth	No charge
X-rays – intraoral periapical – first film	No charge
X-rays – intraoral periapical – each additional film	No charge
X-rays – intraoral – occlusal film	No charge
X-rays – extraoral	No charge
X-rays – extraoral – each additional film	No charge
X-rays – bite-wings single film	No charge
X-rays – bite-wings – two films	No charge
X-rays – bite-wings – four films	No charge
X-rays – bite-wings – additional	No charge
X-rays – panoramic film	No charge
Pulp vitality tests	No charge
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment**)	No charge
PREVENTIVE DENTISTRY	
Dental prophylaxis[2] – adult	No charge
Fluoride application – adult	No charge
Oral hygiene instruction	No charge
Topical application of sealant	No charge
RESTORATIVE DENTISTRY (limitation of four fillings per year)	
Member responsible for cost beyond four fillings per year	
Amalgam – permanent	
One surface	$11
Two surfaces	$14
Three surfaces	$17
Four or more surfaces	$20
Silicate cement (per restoration)	$8

Adult Dental Benefits

DENTAL COVERAGE	MEMBER'S 20% SERVICE CHARGE
RESTORATIVE DENTISTRY (CONT.)	
Filling	
Resin – one surface – anterior	$13
Resin – two surfaces – anterior	$17
Resin – three surfaces – anterior	$21
Resin – four or more surfaces – involving incisal angle	$23
Re-cement inlay	$8
Re-cement crown	$9
Sedative filling	$9
Core build-up, including any pins	$21
Pin retention per tooth, in addition to restoration	$10
Unspecified restorative procedure (acid etch)	$10
ORAL SURGERY	
Routine extraction of one tooth	$13
Routine extraction of each additional tooth	$12
OTHER DENTAL SERVICES	
Stainless steel crowns (limitation of two per contract year)	$29
Prefabricated stainless steel crown – permanent	$32
Prefabricated stainless steel crown with resin window	No charge
Emergency palliative treatment	$50 per visit
Emergency care (out of area) see HealthSelect Dental Limitations (page 35)**	Member pays all costs beyond $50.
Analgesia	$7
Office visit	$5

***Note* – The HealthSelect Dental Benefit Plan Does Not Cover:**

Bridges or bridge repair	Crown repair	Periodontics
Crowns (except stainless steel crowns)	Endodontics	Prosthodontics
	Orthodontics	

HealthSelect does not cover services that are specifically excluded from coverage even when a HealthSelect dentist makes the referral. These services will become member's financial responsibility.

**Need authorization from HealthSelect.

[1]Once per contract year.

[2]Routine cleaning once each coverage year.

Adult Dental Exclusions and Limitations

HealthSelect does not provide coverage for prosthetics or prosthetic repairs. Emergency treatment secondary to traumatic injury to the teeth, gums and/or bone is available within the hospital or outpatient setting. Member may be responsible for payment of follow-up treatments that are not covered services under HealthSelect.

Any services that are not provided by a contracted dentist or prior authorized by HealthSelect (except for urgent/emergent care) are not covered by HealthSelect.

Other Exclusions and Limitations
(Pediatric and Adult Dental Services)

A. Any dental service not addressed in the previous list of Covered Benefits.

B. Gold and precious metals are not covered for tooth restorations/replacements.

C. Bridges, dentures and tooth implants are not covered.

D. Out-of-area and out-of-plan dental coverage is limited to emergencies only and is limited to a maximum coverage amount of $50 per visit. The member is responsible for all charges in excess of $50.

E. Surgical grafting procedures are not covered.

F. Treatment of tooth problems related to congenital or developmental malformations are not covered. This includes, but is not limited to, cleft palate, enamel hypoplasia, fluorosis (brown or white stains on the teeth), maxillary and/or mandibular malformations and anodontia.

G. General anesthetic is not a covered benefit for pediatric dental services. It would be covered in an emergent care setting (hospital emergency room) or in an inpatient setting for treatment of an emergent, traumatic injury to the teeth, gums and bone.

H. Cosmetic treatments and services are not covered.

I. Full-mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for malalignment of the teeth are not covered.

J. Any single procedure or procedures started prior to the date the member became eligible for such services under HealthSelect. Dental treatment in progress at the time of member disenrollment or ineligibility for coverage is not covered by HealthSelect after the disenrollment or ineligibility date.

K. Treatment and/or removal of oral tumors would be covered as a medical benefit, not a dental benefit.

L. Orthodontic care and supplies, including x-rays for orthodontic treatment and extractions are not covered.

M. Prosthetics repair and oral surgery (except for routine extraction).

N. No endodontics for adults.

O. No periodontics for adults.

P. No orthodontics for adults and children.

Q. No prosthodontics for adults.

R. Prophylaxis will be provided only once every contract year for adults. Additional prophylaxis requires prior authorization from HealthSelect.

S. Full-mouth x-rays will be provided no more than once every contract year.

T. Any single procedure or procedures (including root canals) started prior to the date the member became eligible for such services under this agreement will not be covered.

Helpful Hints

- Always show your HealthSelect ID card when you present for care at a participating physician's office/clinic, hospital or other HealthSelect care site.
- Call your Primary Care Physician (PCP) to schedule your initial visit before you become ill. This will allow you to get to know your PCP better and for your PCP to assess your overall health status soon after you are newly enrolled into HealthSelect.
- Be sure to have your medical records transferred immediately when you change your PCP.
- Call the MIHS Health Plans Customer Service Department to report any change of address, telephone number, etc. Notify your PCP of these changes also.
- Always arrive at your appointment approximately 15 to 30 minutes ahead of your appointment time. This will allow you the opportunity to sign in and verity your insurance information in advance of your actual appointment time.
- During normal business hours, 8 a.m. to 5 p.m., always contact your PCP should you have urgent health care needs. Your PCP will either request that you come to his office or direct you to an Urgent Care Center or emergency room, depending on the severity of your illness, injury or medical condition.
- If you have a non-urgent or non-emergent need to see a physician after normal business hours, (5 – 8 p.m.) on weekends and holidays (8 a.m. – 4 p.m.), you may choose to visit one of five NEXTCARE After Hour primary care locations. See your Provider Directory.

HealthSelect

Health Club Attendance Certificate 2001

HEALTHSELECT MEMBER NAME _____ MEMBER I.D. NUMBER _____

MEMBER ADDRESS _____ CITY/STATE _____ ZIP _____ PHONE NUMBER _____

NAME OF HEALTH CLUB _____ PHONE NUMBER _____

Health club staff: please sign and date to signify completion of each workout by the member

Month 1

Workout 1	Workout 2	Workout 3	Workout 4	Workout 5	Workout 6	Workout 7	Workout 8

Month 2

Workout 1	Workout 2	Workout 3	Workout 4	Workout 5	Workout 6	Workout 7	Workout 8

Month 3

Workout 1	Workout 2	Workout 3	Workout 4	Workout 5	Workout 6	Workout 7	Workout 8

Month 4

Workout 1	Workout 2	Workout 3	Workout 4	Workout 5	Workout 6	Workout 7	Workout 8

Month 5

Workout 1	Workout 2	Workout 3	Workout 4	Workout 5	Workout 6	Workout 7	Workout 8

Month 6

Workout 1	Workout 2	Workout 3	Workout 4	Workout 5	Workout 6	Workout 7	Workout 8

Congratulations! You are eligible to receive the HealthSelect $75 incentive award for active use of your health club. Once this record of your workouts is completed, submit to HealthSelect to receive your incentive award.

MIHS Health Plans Customer Service Department
2502 East University, Suite 125
Phoenix, AZ 85034

HealthSelect

2001 Wellness Activities Certificate of Completion

HEALTHSELECT MEMBER NAME _____ MEMBER I.D. NUMBER _____

MEMBER ADDRESS _____ CITY/STATE _____ ZIP _____ PHONE NUMBER _____

NAME OF PHYSICIAN _____ PHONE NUMBER _____

Please sign and date to certify member's completion of wellness activities

Pap smear test for women age 18 and older

SIGNATURE OF PHYSICIAN _____ DATE OF PROCEDURE _____

Mammogram for women age 40 and older

SIGNATURE OF PHYSICIAN _____ DATE OF PROCEDURE _____

Annual physical exam for men age 40 and older

SIGNATURE OF PHYSICIAN _____ DATE OF PROCEDURE _____

Completion of smoking cessation program through a non-profit community agency

AGENCY SIGNATURE _____ CONTACT NAME _____ DATE PROGRAM COMPLETED _____

Congratulations! For each of the wellness activities documented above, you are eligible to receive a $25 gift certificate. Once this certificate is completed, submit to HealthSelect to receive your gift.

MIHS Health Plans Customer Service Department
2502 East University, Suite 125
Phoenix, AZ 85034

You may receive additional forms by contacting the Customer Service Department at 602-344-8760 or 1-800-582-8686.

HealthSelect

2001 Childhood Immunization Certificate of Completion

Member, please note:
To be eligible to receive this incentive, your covered child must be between the ages of 0 and 5.

HEALTHSELECT MEMBER NAME _____ MEMBER I.D. NUMBER _____

CHILD'S NAME _____ CHILD'S BIRTH DATE _____

MEMBER ADDRESS _____ CITY/STATE _____ ZIP _____ PHONE NUMBER _____

NAME OF PHYSICIAN _____ PHONE NUMBER _____

Physician: Please sign and date to indicate that the above named child has received all of the recommended immunizations for his/her age during calendar year 2001

I certify that the child named above is 5 years old or younger and has received all of the recommended immunizations for calendar year 2001.

SIGNATURE OF PHYSICIAN _____ DATE _____

Congratulations! Because you have made the healthy choice to insure your child has up to date immunizations, you are eligible to receive a $25 gift certificate. Once this certificate is completed, submit to HealthSelect to receive your gift.

MIHS Health Plans Customer Service Department
2502 East University, Suite 125
Phoenix, AZ 85034

You may receive additional forms by contacting the Customer Service Department at 602-344-8760 or 1-800-582-8686.